Dr. Jessica Greaux, D.C.

6330 Telegraph Ave, Oakland, CA 94609
P: 510.601.6330 ▪ F: 510.601.6331

Patient Intake Form

Kindly fill out the following information as completely as possible so that we may better serve you.

Full Name: ____ Date: ______________________
First MI Last

Address: __________________________ City:__________________ State: ______ Zip: _____________

Age: _______ Birth Date: ______________ Female:_____ Male: _____ Gender Neutral: __________

Email Address: ________________________________

Home Phone: __________________ Work Phone: __________________ Cell/Other: ____________________

I am (circle) Under Age18/ Single/ Married/ Divorced/ Widowed/ Separated/Domestic Partnered

Employer: ____ Occupation: __________________

Business Address: __________________________ City: __________________ State: ______ Zip: ________

Spouse's Name: ______________________________________ Spouse's Date of Birth: _________________

Emergency Contact/Phone #: _______________________Who can we thank for referring you?______________

Payment Information

Payment is due at time of service.

Person Responsible for Payment: ____

Driver's License # and state: ____________________ Phone: ______________________ Date of Birth: _______

What services do you seek?

___Chiropractic Previous Chiropractic (DC name/last visit):________________________________

___A.R.T. (Active Release Technique) ____Graston ____Exercises _____ Physical Therapy

Main complaint(s) today: ____

____

____

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Office Hours:
The doctors are available to see patients Monday through Friday by appointment only.

Rescheduling an Appointment:
In order to provide the best care to all patients, please **provide 24 hours notice** if you are unable to make your appointment. Special circumstances aside, an $80 fee will be charged if we do not receive 24 hours notice. ***Please note that insurance companies will not pay for this fee.***

Terms of Acceptance of Care

Assignment & Release

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goals. It is important that each patient understand both the objective and the method that will be used to attain these goals. This will prevent any confusion, misunderstanding or disappointment with your care in this office.

Adjustment: *An adjustment is the specific application of forces to facilitate the correction of joint restrictions. Our chiropractic method of correction is by specific adjustments of the spine and extremities.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

I, ____, have read and fully understand the above statements.
(print name of patient)

Signed ____ Date ____________________________

(If patient is a minor, parent/ legal guardian must sign)

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A Performance Therapy Clinic

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Health Questionnaire

Date: ___________________________

Patient Name: ____ Date of Birth: ____

Height: ____ Weight: ____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

____

____

List any trauma, including but not limited to motor vehicle accidents, sports injuries and broken bones:

____

____

List any surgeries or hospitalizations you have had complete with the month and year for each:

____

____

____

List anything you are allergic to: ____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): ____

____

Do you exercise? Yes No Hours per week ____________What activity(s)? ____

____

Do you wear? Heal lifts Arch supports Prescription Orthotics

For women: Are you pregnant or nursing? Yes No If pregnant, How many weeks? _______________________________________

Date of last menstrual period: ____

History of Treatment

Primary care physician: ____ Office: ____

Date last seen: ____ May we update them on your condition? ___Yes ____ No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _______________

____

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Abdominal Pain	○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○
Abnormal Weight gain/loss	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder	○	○
Allergies	○	○	Epilepsy	○	○	Low back pain	○	○
Angina / Chest pressure	○	○	Excessive thirst	○	○	Mid back pain	○	○
Ankle/foot pain	○	○	Fainting	○	○	Neck pain	○	○
Arthritis	○	○	General Fatigue	○	○	Painful Urination	○	○
Asthma	○	○	Hand pain	○	○	Prostate Problems	○	○
Bladder Condition	○	○	Heart attack	○	○	Shoulder pain	○	○
Birth Control Pills	○	○	Hepatitis	○	○	Smoking/tobacco Use	○	○
Cancer	○	○	High blood pressure	○	○	Stroke / Aneurysm	○	○
Chest Pains	○	○	Hip/upper leg pain	○	○	Systematic Lupus	○	○
Chronic Sinusitis	○	○	HIV/AIDS	○	○	Thoracic Outlet Syndrome	○	○
Concussion	○	○	Hormone Therapy	○	○	Tumor	○	○
Depression	○	○	Jaw pain	○	○	Ulcer	○	○
Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Upper back pain	○	○
Dizziness / Light-headed	○	○	Kidney Stones	○	○	Wrist pain	○	○

Additional comments you would like the doctor to know: ______________________________

____

____

____

____

____

Patient's signature: ____________________ **Doctor's signature:** ____________________

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NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in

the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Innersport

Jessica L. Greaux, D.C.

6330 Telegraph Ave.

Oakland, CA 94609

drjess@innersport.com

(510) 601-6330

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

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4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

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3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

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9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

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PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (5 pages) for Innersport and Dr. Jessica L. Greaux, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

____________________________________ ____________________

Patient Signature Date

____

Print the Patient Name